PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2016

By
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CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Salve Stanilla Vincent** during the year 2014-2016. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD 1: Personality Assessment

Name	: Mr S
Age	: 53 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Bengali
Education	: B.Sc
Occupation	: District Fishery Officer
Socio-economic status	: Middle
Residence	: Urban
Informant	: Mr.S and his wife

Presenting complaints:

Alcohol use	27 years
Smoking beedis	30 years
Cannabis use	7 years

History of presenting complaints:

Mr.S presents with a history of alcohol use for 27 years in dependence pattern characterized by withdrawal symptoms, salience, craving and inability to control the alcohol amount.He initially started drinking one bottle of beer once a week with friends. Gradually, he began to drink more frequently and required more and more amount of alcohol to experience the high. He began to drink up to 720ml of hard liquor. He gradually began to start drinking alone and would bring the alcohol to his home. He also began develop tremors when he remained abstinent from alcohol and began to consume alcohol in the morning so that the tremors subsided and he was able to go for his occupation. Secondary to his alcohol use, he began to have problems at home with his wife and he would get in to frequent arguments with over his drinking habit. He had never made any significant effort to abstain from alcohol in the past and his maximum period of abstinent was three days. He relapsed secondary to craving for alcohol. His last drink was on 23rd July 2015.

There is history of using cannabis for the past four years. However, the amount of cannabis used was unclear. He also used to gamble in the past and had stopped for the past five years. He smokes ten beedis per day for the past thirty years.

There have been no history of complicated withdrawal in past, jaundice, hematemesis, road traffic accidents or medico legal cases. There is no history of pervasive mood symptoms, obsessive compulsive disorder or anxiety disorder.

Past history:

There is history of dyslipidaemia and hypertension for the past five years.

Treatment history:

There is no history of any past attempts at detoxification or deaddiction.

Developmental history:

Details regarding his antenatal period was unavailable. His birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. His developmental milestones are reported to be normal.

Family history:

There is history of bipolar affective disorder in his father and a depressive illness in his mother. There is history of alcohol use in many first and second degree relatives.

Educational history:

He has completed his Bachelor's degree in science. He was an average student in his school and college.

Occupational History:

He currently works in the Department of Fisheries as a district fishery officer.

Sexual History:

He was heterosexual in his sexual orientation. He denied any high risk sexual behaviour. He denied any sexual dysfunction and did not have any misconceptions.

Marital History:

He is married to Mrs. B who is 47 years old and works as a Nurse. They have a son.

Premorbid Personality:

He was described to have low frustration tolerance and was impulsive, manipulative, and high novelty seeking behaviour. He was not very religious and did not have high religious standards.

Physical examination:

His vitals were stable and his systemic examinations were within normal limits.

Mental Status Examination:

He was moderately built and well kempt. He maintained good eye contact. Rapport was difficult to be establish. There was no restlessness. His level of activity was normal. There were no abnormal involuntary movements. He was co-operative during initial interview. His speech was of normal tone, pitch, reaction time and speed. His mood was euthymic with normal range and reactivity of affect. He denied any suicidal ideas. There were no abnormalities in his form and stream of thought. He expressed depressive ideations. He denied delusions. There were no thought broadcast, thought insertion or withdrawal. There were no perceptual abnormalities. There were no obsessions or compulsions. He was oriented to time, place and person. His attention and concentration could be aroused and was sustained. His immediate, recent and remote memory were intact. His intelligence was average and social judgement was intact. He was in the contemplation stage of motivation and had an internal locus of control.

Provisional diagnosis

- Alcohol dependence syndrome - uncomplicated withdrawal
- Nicotine dependence syndrome- active use
- Past history of Cannabis use

Aim for psychometry

- To identify and explore significant personality factors influencing the psychopathology.

Tests administered

- 1. Thematic Apperception Test
- 2. Sacks Sentence Completion Test
- Cattell's 16 P F Questionnaire

During the entire exercise, he was cooperative. He could comprehend the instructions and paid adequate attention.

Rationale for the tests

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

16 PF Questionnaire is a self-report personality test developed over several decades of empirical research by Raymond B. Cattell, Maurice Tatsuoka and Herbert Eber. The 16PF provides a measure of normal personality and helps to help diagnose psychiatric disorders, as well as help with prognosis and therapy planning.

Test findings

During the initial assessment sessions he was found to be anxious however became more comfortable as the testing proceeded. He was cooperative for testing and his comprehension of test instructions was fair. He was fairly attentive.

Thematic Apperception Test

Most of his stories are brief and have a dominant theme of anxiety, sadness and failure. The dominant needs are need for autonomy, achievement, and harm avoidance. The major conflicts observed are between a need for autonomy vs. need for deference and abasement. The stories show a strong desire to be independent but often passively waiting for the situation to set right by itself rather than actively doing something about it. There is a hope of overcoming the failures. There is also fear of punishment for wrong deeds and of insecurity.

Sacks Sentence Completion Test

The protocol reveals that he was attached to his father and was extremely disappointed that his father is not alive. His attitude towards his mother reveals that he was not very emotionally attached with her. It also reveals fear of being rejected and criticized. He has a poor self-esteem. There is guilt feeling about his past lifestyle and he optimistic about his future and has big goals in life. He does not seem to have many friends and he is on fair terms with his superiors. He however doesn't value the staff working under his supervision. His attitude towards his colleague is professional. His attitude towards women is respectful.

16 PF Questionnaire

The protocol indicates that he is an outgoing person who tends to be caring, sympathetic and expressive. He has good problem solving skills and tends to grasp abstract relationships easily. He tends to be calm and face stress fairly well but at the same time tends to be also be prone to manifesting aggression,

dominance and being stubborn and headstrong. This is suggestive of passive aggressive tendencies. He tends to be genuine and unpretentious but may come across as socially clumsy. He tends to be apprehensive and worrying and may suffer from feelings of insecurity and low self-confidence.

Conclusion

The test findings reveal that Mr. S has strong attachment to family especially his father. He has good problem solving skills and has passive aggressive traits. He also tends to worry a lot and has low self-confidence. This suggests that while he may be respond to situations in an emotional manner, there are no prominent personality traits that stand out.

Management

Mr.S was admitted for detoxification and deaddiction. Detoxification was done with benzodiazepines. Rapport was established. Motivational enhancement techniques were used. He was helped to visualize his ambivalence and was encouraged to recognize his strengths and ability to change. He was taught to identify the states and triggers for relapse and was taught relapse prevention strategies

CASE RECORD 2: Intelligence Assessment

Name : Master BS

Age : 15 years 3 months

Sex : Male

Education : Standard IX

SES : Middle

Religion : Hindu

Informant : Parents

Reliability : Good

Presenting complaints

Preoccupation

Smiling to self

Irritability

Disobedience

Poor academic performance

For 2 years insidious in onset.

History of presenting complaints

BS presented with episodic illness of 2 years duration with an initial episode characterized by low mood, decline in academic performance, easy fatigability, increased crying spells and inability to concentrate followed by an episode suggestive characterized by increased speech, increased psychomotor activity and sexualized behaviour, Each episode lasting for 2 months.

Present admission was for preoccupation, irritability, smiling to self and poor academic performance all this in the absence of substance use, specific anxiety disorder or obsessive compulsive disorder.

Past history

There was no significant past medical history

Birth and development history

Prenatal: Planned pregnancy with nil significant history

Perinatal: Full term caesarean delivery at hospital with new-born weighing 3.5 Kg who cried soon after birth

Postnatal: Breast fed upto 2 years of age. He was immunised for age.

The developmental milestones were reported to be normal.

Emotional development and temperament

He was described to be anxious around strangers. He had difficulties in reciprocal social interactions, poor peer relationships, rigidity and unusual fascinations since early childhood. He was also described to have features suggestive of ADHD with impulsivity, hyperactivity and inattention.

School history

He is studying in 9^{th} standard. The medium of instruction is English. He was reportedly scoring around 50% marks throughout.

Systemic examination: Vital signs were stable and systemic examination was within normal limits.

Mental status examination:

He was moderately built and nourished. He was well kempt and maintained eye contact intermittently. He was cooperative. His primary mental functions were intact. He was euthymic. His speech was normal. He had no hallucinations or delusion. His abstract thinking and general knowledge were poor. Insight and judgement were normal.

Provisional diagnosis

Bipolar Affective disorder.

Attention Deficit Hyperactivity Disorder**.**

PDD NOS

Intellectual disability

Aims of psychological testing

As history was suggestive of poor scholastic performance and mental status examination revealed impairment in tests of abstraction and general knowledge, IQ assessment was imperative.

Tests administered

1. Vineland Social Maturity Scale (VSMS)

2. Wechsler's Intelligence Scale for Children (WISC IV India)

Rationale for the tests

1. VSMS was used to assess the social adaptation and social age
2. WISC IV India was used to assess intelligence

Behavioural observations

Master BS was co-operative and willing for the tests. He was able to comprehend instructions. He intermittently had difficulty in paying attention. No anxiety was observed.

Test findings

1. Vineland Social Maturity Scale:

The Social Age (SA) of master BS was 10.42years, which was low for his age. The profile of age levels across the functions was as follows:

Self-help general 7.28years

Self-help dressing 12.38 years

Self-help eating 9.03 years

Communication 10.30 years

Self-direction 11.45 years

Socialisation 12.30years

Locomotion 9.43 years

Occupation 11.25 years

2. WISC IV

His Full Scale IQ was 100 indicative of average intellectual functioning

Verbal comprehension - 83

Perceptual reasoning -123

Working memory -100

Processing speed - 94

The IQ of Master BS was 100, which indicated average intelligence.

Impression

The tests revealed that master BS had mild impairment in verbal comprehension and processing speed. The impairment in the broader domain of Verbal comprehension may be due to lack of adequate knowledge about the social environment, limited word fluency and difficulties in expressive communication. Impairment in processing speed can be attributed to his inattention intermittently. His perceptual reasoning score is above average showing that his ability for logical reasoning and manipulation is superior to his other abilities. The IQ according to the WISC IV was average. However the social maturity as assessed on the VSMS is below age level. This is reflective of his social skill deficits which is a characteristic feature of PDD.

Management

1. The parents were educated about his diagnosis and its implications. They were allowed to ventilate and support was provided.
2. The parents were taught about Behavioural management techniques and differentially rewarding skill behaviour and problem behaviour.
3. The importance of maintaining Activities of Daily Living Chart and following the token economy programme was stressed.
4. In view of his learning difficulties and attention problems a step down in curriculum was suggested.
5. The need for social skills training was emphasized.
6. To enhance the learning and implementation of behavioural strategies, an inpatient stay was recommended.
7. He was continued on mood stabilizers.

CASE RECORD 3: Diagnostic Clarification

Name : Ms H

Age : 19 years

Sex : Female

Marital status : Unmarried

Religion : Christian

Language : Tamil

Education :Bachelor'sDegree in nursing(1st year)

Occupation : Student

Socio-economic status : Middle

Residence : Urban

Informant : Ms H and her mother

Presenting complaints

- Repetitive thoughts about contamination, symmetry and blasphemy
- Repetitive acts such as chanting to God, praying and rewriting
- Irritability
- Hearing voices commanding her to repeat prayers and commenting on her actions.

History of presenting illness:

Ms.H presented with history of continuous illness characterised by repetitive thoughts of sexual nature including incestuous content, blasphemy. She reported these thoughts to be intrusive and causing extreme distress due to their disturbing content. Frequent attempts to resist these thoughts have been unsuccessful resulting in more distress. She began to chant and pray repetitively to counter these thoughts. She also began to spend excessive time of keeping things in symmetry and arranging things. These continued to perform these behaviours despite knowing that they were irrational. She reported a decrease in her anxiety temporarily following the completion of her rituals of chanting, praying and arranging. These symptoms worsened following her admission into a college six months back.

Since the past one month, there is history of being controlled by someone who gives her commands. She reported to hear multiple male and female voices commanding to her to take up the correct posture while praying. She was however unsure about these voices were from within her or from outside of her. She has assaulted her roommate 2 days prior to admission and has threatened to kill her, because of this she was dismissed from her college for few days.

There is past history of episodes of autonomic arousal and flashbacks of an instance when she was a witness to a sexual assault by her father on her mother following an argument between them. Currently she does not report of the same.

Her biological functions were normal and there was no significant social or occupational impairment secondary to her symptoms.

There was no history suggestive of organicity or seizures.

There was no history of substance use.

There was no history of any delusions

There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

There was no history of conduct disorder or pervasive developmental disorder.

Treatment history

She had consulted her college's Psychiatrist but details regarding treatment was not available.

Family history

She is the elder of two siblings. Her parents had separated five years back. Her father has remarried.

Developmental history

The antenatal period was supervised and uneventful. Her birth was full term lower segment caesarean section delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. Her developmental milestones are reported to be normal.

Educational history

She is pursuing her Bachelor's Degree in Nursing and is currently in her first year. She is reported to be an above average performer in academics securing 78 % and 83% in tenth grade and twelfth grade examinations respectively. Her extracurricular interests include dancing and singing.

Sexual development

Her menstrual cycles are regular and she denied any high risk sexual behaviour.

Marital history

She is unmarried

Premorbid personality

She is described to be ambitious, social, energetic, and active in extracurricular activities and have high moral and religious standards.

Physical examination

Her vitals were stable and systemic examination was within normal limits.

Mental status examination

She is well kempt, cooperative and rapport was established. She was alert and lucid. There were no abnormal motor movements. Her speech was spontaneous, fluent, normal speed, reaction time and productivity. Her mood was dysphoric with normal range and reactivity. She denied suicidal ideations. Her thought content revealed obsessions with themes of incest, blasphemy, contamination and symmetry. There were no perceptual or volitional abnormalities .She had compulsions of chanting, repeating prayers, rewriting. She was oriented to time, place and person. Her recent, remote and immediate memory was intact. Her attention could be aroused and sustained. Her intelligence was average . Her insight was partial and her judgement was intact.

Differential diagnosis

- Obsessive compulsive disorder – mixed obsessional thoughts and acts
- Undifferentiated schizophrenia period of observation less than one year

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Rorschach Inkblot Test

2. Thematic Apperception Test

3. Sentence Completion test

Behavioural Observation

She was enthusiastic about participating in the assessment. She was cooperative and was able to understand the instructions well. She was able communicate adequately. There was no performance anxiety noted.

The Rorschach Inkblot Test – Klopfer System

Rationale

It provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology

Test findings

In the Rorschach protocol, she has given 46 responses indicating increased productivity and quick and hurried mentation. She has a tendency to be impulsive with immediate gratification of needs. There appears to be significant amount of inner distress which may result in impairment in handling day to day issues. There are indication of repression and denial of need for affection. Predominance of FC responses and lack of CF and C responses indicate the presence of excessive control and adequate social expression but without any real emotional involvement. The protocol indicates a lack of

interest in seeking relationship between separate facts of experience and achieving an organized view of the world. She has adequate creative potential to back up her aspirations. She tends to stick to practical ways of looking at things. Edge details indicate a tendency to skirt around the fringes with a fear of getting into anything too deeply. The succession of the responses are fairly rigid with elaboration of numerous responses. Blood responses are present indicative of anxiety. There are adequate number of human responses indicating an interest in and sensitivity to others. There are adequate number of popular responses indicating ties with reality.

Thematic Apperception Test

Rationale is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test Findings

Her stories were brief and the content of most of her stories revolved around the fear of punishment and of being criticised or hurt. There was also a fear of being exhausted and committing mistake/sin. The dominant needs are need for achievement, affiliation and acceptance. There is also fear of humiliation in front of parents and being punished by God. Feelings of shame, guilt and frustration are the common emotions portrayed in the characters in the stories. There is a feeling of loneliness and seeking someone to talk to.

Sack Sentence Completion Test:

Rationale is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test Findings

The protocol indicates a negative attitude both parents with expression of hatred and anger towards them. There is significant fear regarding her obsessions. Her attitude towards her abilities and future is positive and optimistic. There are no indicators of any low self-esteem. Her attitude towards others in positive and expresses healthy interpersonal relations with her others and has a strong need to please others. There is regret and sadness regarding her past with expressions of sorrow and feelings of loneliness. Her attitude towards women is pessimistic.

Conclusion

The test findings reveal the presence of loneliness, low self-esteem which are compensated with a strong desire to please others. There is strong interpersonal issues with parents. The test findings do not reveal the presence of any psychosis.

Management

Following diagnostic clarification and ruling out psychosis and confirmation of Obsessive Compulsive Disorder, she was started on Cap. Fluoxetine which was titrated up to 40mg.day. Emphasis was on psychological management. Ms. H and her mother were psychoeducated about the nature of her illness. Non pharmacological strategies of distraction techniques, thought stopping, cognitive behavioural therapy were taught. She also underwent occupational therapy. She improved significantly at discharge and her distress was reduced significantly over the course of admission.

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CASE RECORD 4: Diagnostic Clarification

Name : Miss SG

Age : 17 years

Sex : Female

Marital status : Unmarried

Religion : Hindu

Language : Bengali

Education : 12th

Socio-economic status : Lower Middle

Residence : Rural

Informant : Miss SG and her parents

Presenting complaints

Episodes of Decreased speech, occasional crying spells, Social withdrawal,

Disorganized behaviour like going out of the house suddenly, decreased appetite, self-injurious behaviour.

Episodes of increased speech, increased psychomotor activity, irritable mood.

History of presenting illness

Mr SG was apparently well till 4 years ago when she started interacting less with family members and friends, she seemed very sad and she started having decreased speech, Crying spells occasionally, self-injurious behaviour, Disorganized behaviour like going out of the house suddenly without any reason and then coming inside which lasted for 1 month, She had similar 3 episodes in past 4 years.

Along with this she had episodes when she had excessive talk, increased activity, irritability, referential ideas which lasted for 1 month. Similar episodes around 4 times.

She started missing her school due to this and stopped going out with friends. There was impaired biological functioning. There was however no symptoms of delusion of persecution or reference or hearing of voices.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

There was no history of substance use.

There was no history of conduct disorder or pervasive developmental disorder.

Treatment history

She was treated elsewhere with Lamotrigine and developed drug rash. She had a good response on Lithium, and SSRI's in the past. She was on benzodiazepine for 3 years.

Family history: She is the youngest daughter of her parents. Her father is farmer and mother is housewife. She has an elder brother who is 23 year old who is doing his BA. She stays in nuclear family. Father is very critical about all the things and doesn't like SG mixing with other boys. There is a family history of? Psychosis in paternal cousin.

Birth and Developmental history:

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

She was studying in 12th standard. Her academic performance was reportedly average. She however had no difficulty in obeying teachers. She was motivated to learn.

Sexual development

She had female gender identity and heterosexual orientation. She had regular menstrual cycles.

Premorbid personality

She had limited social interaction. She was described as being calm with few friends.

She however used to go out with friends. She liked watching TV and movies.

She likes drawing and liked everything already scheduled.

Physical examination

Her vitals were stable. Systemic examinations were within normal limits.

Mental status examination

She was moderately built and nourished. She was well-kempt. Rapport was poor to establish initially however later it improved. Her higher mental functions were intact. She had reduced range and delayed reactivity of affect. Depressive cognitions were present without any suicidal ideation. She denied any psychotic phenomena. Insight and Judgement were impaired.

Provisional diagnosis

BIPOLAR AFFECTIVE DISORDER – CURRENT EPISODE SEVERE DEPRESSION WITHOUT PSYCHOTIC SYMPTOMS

UNDIFFERENTIATED SCHIZOPHRENIA

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Beck Depression Inventory (BDI)
2. BPRS RATING SCALE
3. Thematic Apperception Test (TAT)
4. Draw a Person Test (DAPT)

Behavioural observation

She was fairly cooperative during the period of assessment. She could comprehend the instructions and her attention was adequate. Her motivation was fair.

Rationale and Findings

1.**Beck Depression inventory**(**BDI**, **BDI-1A**, **BDI-II**), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression

Test findings

She scored 24/63 in beck's depression inventory which points towards moderate depression.

2. **BPRS**

The **Brief Psychiatric Rating Scale (BPRS)** is rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored. The scale is the one of the oldest, widely used scales to measure psychotic symptoms and was first published in 1962.

Test Findings: She scored 40/112 which indicates that there was no significant psychotic illness.

2. Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

On the TAT protocol, most of the stories were well structured. The recurrent themes were that of some natural calamity and destruction. Mostly females have been identified whose prominent needs were need for achievement and approval of others. Most of the stories talk about guilt about doing a mistake and others (especially mother) being upset. The significant conflicts that surfaced were acceptance versus rejection. The main anxieties were that of failure to achieve. However the outcome in most stories was sad.

3. Draw a Person Test (DAPT)

Rationale and Findings:

The Draw-a-Person test (DAPT, by Karen Machover) is a psychological projective personality test used to evaluate children and adolescents for a variety of purposes.

Test findings

She drew a picture of girl holding a flower in hands. She was very particular about drawing neat lines and hardly used eraser. She first made a rough picture with dots and then traced it for fair. The pencil pressure was high and she said the girl is looking okay and that she is carrying a flower to give it to someone for asking forgiveness. The drawing was very neat.

Conclusion

She was admitted for diagnostic clarification between severe depression without psychotic symptoms and undifferentiated schizophrenia. Undifferentiated Schizophrenia was considered in view of negative symptoms and affective symptoms. However, the tests revealed that Miss S has some underlying depressive cognition.. All her stories came with central themes of being sad, of guilt and asking forgiveness, there were no disorganized thoughts, coming out of the assessments. Also few Obsessive compulsive traits were also seen. So the diagnosis of severe depression without psychosis was considered.

Management

She was admitted in view of diagnostic clarification and drug rationalization. She was started on Tab carbamazepine, however she developed drug rash and was admitted under medicine .In view of this, Tab Lithium and Tab. Quetiapine was started.. Behavioural strategies of exposure and response prevention and ADL were also employed. After serial interviews with the patient; ward and OT observations, her diagnosis was changed from Undifferentiated Schizophrenia to BPAD severe depression without psychotic symptoms.

Non-pharmacologically, rapport was established with the patient. Her family was allowed to ventilate and was psycho educated about the nature of his illness, course, prognosis and need for long term treatment and regular follow up. She was seen to minimally improve in Occupational Therapy. At the time of discharge, she had marginal improvement in the symptoms.

CASE RECORD 5: Neuropsychological Assessment

Name : Sr.D

Age : 41 years

Sex : Female

Marital status : Single

Religion : Christian

Language : Malayalam and English

Occupation : Nun

Socio-economic status : Middle

Residence : Urban

Informant : Sr.D and colleague

Presenting complaints

Decline in memory since four years

Mode of onset insidious

History of presenting illness

Sr.D presented with four years history of gradual deterioration in memory. The symptoms were first noticed by others staying with her, who found that she was forgetting recent conversations and appointments, misplacing things, and taking others' belongings unknowingly. She was also found to experience difficulty in orienting herself to new places and took longer to familiarize

herself with new surroundings. The symptoms led to impairment in her day to day functioning as she could not remember specific duties given to her. She also reported difficulty in remembering names of people occasionally, and difficulty in doing mental calculations. There was no history of difficulty in performing learned actions, difficulty in having conversations, or difficulty in concentrating on a task.

Sr.D would show mild irritability when confronted with her mistakes and initially used to deny that there was any problem with her memory. There was no history of any personality change or mood changes as observed by the informants. There was no history of slowing of speech or of motor activity, change in posture, abnormal involuntary movements, or emotional lability. There was no history of vision problems, incontinence or falls. There was no history suggestive of delusions or hallucinations.

She expressed sadness over her parents' death and guilt over not being able to take care of her mother during her illness. However there were no history of pervasive depressed mood, loss of enjoyment, terminal insomnia, and diurnal variation in mood or fatigability.

There was no history of head injury, seizures, CNS infections or thyroid disorders. There was no history of anxiety symptoms or obsessive compulsive symptoms. There was no history of any psychoactive substance use.

Past history

Nil significant**.**

Family history

There is family history of probable early onset dementia in her mother and alcohol dependence syndrome in her father.

Birth and development history

She was born of a non-consanguineous marriage. Other details regarding her birth and development were unavailable due to lack of proper informant.

Educational history:

She has completed her Bachelor's degree in Arts. She is described to be average in her studies and had good relationship with teachers and her peers.

Occupational history

She joined a convent as a nun immediately after her studies and she performs a wide range of roles in the convent such as gardening, teaching, social work and prayer.

Premorbid personality

She is described to be an introverted person who had very high religious and moral standards. She was responsible and meticulous in her day to day activities.

Central nervous system

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Normal

Meningeal signs - Absent

Skull and spine - Normal

Mental status examination

She was moderately built and nourished, and was well kempt. She maintained good eye contact. Rapport could be established. She was mostly cooperative towards the therapist but was defensive when asked about her deficits. There were no abnormal motor movements. Her speech was relevant with delayed reaction time, normal tone and decreased productivity. Her mood was euthymic with restricted ranged and decreased reactivity of affect. She denied suicidal ideations. There were no abnormalities in her form and stream of thought. Her content of thought did not reveal any delusions or depressive cognitions. She was oriented to place and person but not time. Her immediate and remote memory was intact but her recent memory was impaired. Her attention could be aroused and sustained. Her abstract thinking was normal and her intelligence was average. Her insight was grade III and her judgement was intact.

Differential diagnosis

- DEMENTIA
- COGNITIVE DEFICITS SECONDARY TO DEPRESSION

Aims of neuropsychological testing

1. To find out the cognitive profile of Sr.D

2. To relate the findings to clinical presentation

Test Administered:

1. Mini-mental state examination (MMSE)

2. NIMHANS Neuropsychological Battery

Mini-mental state examination

The MMSE was developed by Folstein in 1975 and is used widely as a screening tool for gross cognitive impairment. It can help to confirm diagnosis, assess the severity and, monitor the progress and outcome of treatment. MMSE measures orientation, attention and calculation, immediate and short-term recall, language, and ability to accomplish simple verbal and written instruction as well as visual construction. The total score is 30.

Rationale

To screen for and identify areas of cognitive deficits.

Test findings

The MMSE score was 23. The distribution of scores across the domains were as follows

Orientation	3/5
Registration	3/3
Attention and Concentration	5/5
Recall	0/3
Language	7/8
Visuospatial ability	1/1

This indicating with deficits in orientation and short-term recall.

NIMHANS Neuropsychological Battery

The battery was developed by Shobini Rao et al. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population. It comprises of a series of subtests that include

- Digit Symbol Test -- Mental Speed
- Digit Vigilance Test -- Sustained attention

- Trail Making Test -- Focused Attention
- Triads Test -- Divided Attention
- Verbal N Back Test -- Working Memory
- Response inhibition -- Stroop Test
- COWAT -- Verbal Fluency
- Animal Names Test -- Category Fluency
- Tower of London Test -- Planning
- Passage Test and Auditory Verbal Learning Test -- Verbal Learning and Memory
- Rey Complex Figure Test -- Visuo contruction and visual memory

Behavioural Observation

She was alert and cooperative. She had difficulty in comprehending instructions, despite them being translated into her vernacular and they often had to be repeated. There was distress associated with not being able to do well.

Test Findings

Her performance on the Digit Symbol Substitution Test was significantly impaired indicating impairment motor speed. Her performance on the Triads Test as well as in the Digit Vigilance test indicated impairment in divided and sustained attention respectively. However, there were no omission or commission errors in the Digit Vigilance Test. Her performance on the Colour Trails Test A was adequate indicating no impairment in focused attention. Her performance on the Colour Trails Test B was impaired indicating impairment in working memory.

Her verbal fluency in terms of both lexical and categorical were impaired as indicated in the Controlled Oral Word Association Test and Animal Names Test. Her performance on the Stroop Test was impaired indicating impairment in response inhibition. In the Tower of London Test, there were fluctuations in her performance. She appeared very eager to finish solving the problems and hence made more mistakes. She was able to solve the simple problems easily. However, had difficulty in the more difficult problems (4 moves and 5 moves) and required more time and moves to complete them. She was able to solve 7 problems out of 14 problems in the minimum number of moves.

On the Auditory Verbal Learning Test, her performance was significantly impaired with regard to recall and recognition, indicative of deficits in retrieval and storage. On the Rey Complex Figure Test, his performance was impaired in the copying, immediate recall and delayed trials, indicating impairment in visuoconstructive ability and visual memory.

Impression

The assessment indicates significant impairment in temporal lobe functions as well as parietal lobe functions. Specific frontal lobes functions such as verbal fluency, working memory attention and response inhibition were significantly impaired. However, problem solving were relatively intact in comparison to other domains. Overall, the impairment is suggestive of dementia.

Management

Serial mental status examinations and observations in the ward and occupational therapy sessions did not reveal any symptoms of depression or psychosis. Sr. D was observed to have difficulty in orientation, difficulty in remembering faces and recent conversations and occasionally in following instructions. On confrontation she would deny any difficulties and confabulation was present at times.

Neurology consultation was sought based on observation and neuropsychological assessment, and she was advised to follow up after four months with no interventions planned at present.

Sr. D attended occupational therapy sessions regularly which focused on cognitive skills and training. Patient and her superiors from the convent were explained about the diagnosis and its nature, course and prognosis. They were also advised on psychosocial measures including maintaining an active lifestyle, memory exercises and providing environmental cues for orientation.